UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
SEVENTH REGION

OAKWOOD HEALTHCARE, INC.[1]
d/b/a OAKWOOD ANNAPOLIS HOSPITAL
Employer

and CASE 7-RC-21970

LOCAL 79, SERVICE EMPLOYEES
INTERNATIONAL UNION, AFL-CIO
Petitioner

APPEARANCES:

Ronald J. Santo, William M. Thacker, and Claire S. Harrison, Attorneys, of Detroit, Michigan, for the Employer.
Bruce A. Miller, Attorney, and Bruce Tribble, of Detroit, Michigan, for the Petitioner.

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, hereinafter referred to as the Act, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record[2] in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

[1] The Employer's name appears as corrected at the hearing.
[2] The parties submitted briefs, which were carefully considered.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The labor organization involved claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

The Employer, Oakwood Healthcare, Inc. (OHI) owns and operates a large network of hospitals and related health care enterprises. Its Oakwood Healthcare System (OHS) runs four acute-care hospitals; neighborhood and occupational health care centers; specialty care centers for mammography, cardiac rehabilitation, sports medicine, and adolescent health; numerous foundations; and various ancillary services such as laboratories and pharmacies. The Petitioner wishes to represent a unit of 232 registered nurses employed at a single acute-care hospital, Oakwood Annapolis Hospital (Annapolis). The Employer contends that the smallest appropriate unit consists of 1,872 registered nurses employed at Annapolis and its 3 other acute-care hospitals -- Oakwood Hospital and Medical Center (OHMC), Oakwood Heritage Hospital (Heritage), and Oakwood Seaway Hospital (Seaway). The 4 acute-care hospitals are located in the southwestern suburbs of Detroit within a radius of 22 miles.

There is no history of collective bargaining among the acute-care hospital nurses at issue. However, in 1994 the Board conducted a single-facility representation election, and in 1995 a rerun election, among nurses at Heritage. For many years, OHMC's service and maintenance employees have been represented in a single unit by American Federation of State, County, and Municipal Employees, and OHMC's licensed practical nurses have been represented in a single unit by the Licensed Practical Nurses League. Before OHI closed its behavioral medicine facility known as Annapolis-Westland, nurses there were represented in a single-facility unit by the Petitioner.[3] Since 1967, the service and maintenance employees of Annapolis, Heritage, and Seaway have been represented by the Petitioner in a multi-facility unit.

OHI's president and chief executive officer is Gerald D. Fitzgerald. Directly under him is Joseph Diederich, the chief operating officer, who has overall responsibility for health care delivery at the four acute-care hospitals as well as numerous ambulatory, long-term care, and care management facilities and

[3] Annapolis-Westland is separate and distinct from the hospital known as Annapolis herein.

foundations. Due to the complicated series of transactions by which OHI acquired Annapolis, Heritage, and Seaway, those three acute-care hospitals are still nominally owned by a separate subsidiary corporation, Oakwood United Hospitals, Inc. However, OHI manages those hospitals, leases their real property and physical assets, and employs their staffs. In contrast to the situation prevailing at the time of the 1994 Heritage decision and election, Oakwood United Hospitals, Inc. no longer maintains a separate board or management structure.

Of the four acute-care hospitals, OHMC, by far the largest facility, offers the widest range of services, including but not limited to in-patient mental health, obstetrics, specialized cardiac care, neurosurgery, neonatal intensive care, cancer center, and pediatrics. Neither Annapolis nor Heritage offers obstetrics. Heritage, alone among the four hospitals, has a pain clinic, sleep lab, and in-patient rehabilitation unit. Although each hospital operates its own laboratory to perform emergency tests requiring a result in two hours or less, all routine lab tests are performed at OHMC. OHI supports its hospitals and network health care facilities with centrally handled materials management, laundry, patient billing, medical transcription, accounting, payroll, marketing, public relations, human resources, and risk management services. Each of the acute-care hospitals runs its own kitchen, but certain basic foodstuffs such as gravies and soups are prepared at OHMC and then distributed. All OHI job candidates and employees are tracked in a system-wide computer database called PeopleSoft.

The corporate Human Resources Department is headed by Executive Vice President John Furman, who reports directly to President/CEO Fitzgerald. Under Furman are Corporate Director of Employee and Labor Relations Ed Frysinger and Corporate Director of Compensation and Benefits Dan Smorynski. Director of Employee and Labor Relations Verna Bastedo as well as the currently unfilled directors of staffing and human resources report to Frysinger, while a benefits manager, compensation manager, and pension analyst report to Smorynski. The corporate Human Resources Department has developed and issued standardized personnel forms for virtually all events and actions. It has promulgated uniform attendance, leave, and transfer policies and procedures. With the approval of senior management councils, it has formulated, and when necessary it revises, system-wide fringe benefit packages and wage ranges for every job classification. Local managers must use the prescribed forms and may not depart from the established policies, procedures, benefits, and wages. A common employee handbook summarizing these employment matters applies to workers at the four hospitals as well as other OHS facilities and OHI's home care division.

Director of Employee and Labor Relations Bastedo is OHI's labor contract negotiator. She also supervises human resource personnel at individual sites. Stationed at Annapolis are two human resource clerical employees, one

employment recruiter, and one human resource manager; at Heritage, two human resource clericals, a part-time employment recruiter, and a part-time human resource manager; at Seaway, two part-time human resource clericals, a part-time employment recruiter (shared with Heritage), and a part-time human resource manager (shared with Heritage); and at OHMC, three human resource clericals, five or six employment recruiters, and one human resource director. Bastedo assigns human resource professionals to perform tasks at facilities different from their home base when the need arises. On-site human resource staff members answer questions, direct inquiries, and implement but may not modify corporate employment policies and practices. Except for OHMC, which stores employee personnel files at a corporate office known as Village Plaza, the hospitals maintain their own respective personnel files.

The corporate office of staffing coordinates the recruitment of nurses on a system-wide basis. OHS advertises all job openings throughout its system on OHI's web site and in various print and electronic media. It sends recruiters to job fairs. Nurse recruiters concentrate on assigned geographical areas, but will direct interested applicants to job openings at any site. After completing a standard application form, a job candidate receives an initial screening by a nurse recruiter. This involves a preliminary inquiry into minimum qualifications and a background criminal check. The recruiter sends all candidates who pass this minimum threshold to be interviewed by the clinical manager -- the on-site, first-line supervisory nurse -- into whose unit the candidates seek entry. The interviews conducted by the clinical manager explore the applicants' experience levels and clinical competence. An Employer witness testified that the final hiring choice is normally the product of consensus between the recruiter and clinical manager. As far as the record reveals, however, the recruiter does not participate in the clinical manager's interview regarding specific job qualifications. An Employer exhibit culled from one of many written procedures approved by a multi-site body called the Acute Care Nursing Operations Council states that the clinical manager selects the most qualified candidate and informs the nurse recruiter of the decision.

All employees covered by the handbook described above are subject to the same progressive disciplinary system. For minor infractions, the progression is counseling, a first and second written warning, a three- or five-day suspension, and finally termination. Major infractions may meet with more severe punishment. The nurse's on-site immediate supervisor undertakes the counseling and initiates the warnings. According to the handbook, suspension decisions originate with local nursing management, but must be reviewed by human resource personnel on site in order to assure consistent and equitable treatment. Terminations require the approval of a corporate vice president. The record does not reveal whether, or how often, corporate human resource officials countermand nursing managers' suspension and discharge recommendations. All discipline is

recorded on standard corrective action report forms and filed with the Human Resources Department.

The same employee handbook outlines a problem resolution mechanism for use at the hospitals and elsewhere. Steps one and two of the procedure are meetings between the aggrieved nurse and on-site nursing supervision. Step three involves a human resource representative who may be either based at the aggrieved nurse's hospital or imported from another site. Directors of Employee and Labor Relations Bastedo or Frysinger address grievances at step four. If the dispute arises out of a suspension or termination, impartial arbitration is available as a fifth and final internal step.

The registered nurses' chain of command begins with team leaders and charge nurses, who make patient-care assignments. The first-line statutory supervisors are the assistant clinical managers, operating room (OR) service managers, and pre-admission testing coordinators. Annapolis has 16 assistant clinical managers, 3 OR service managers, and 1 pre-admissions testing coordinator. Next in line are clinical managers, who have general responsibility over particular nursing units. Annapolis has 7 clinical managers. Clinical managers report to clinical nurse supervisors, who oversee the nursing care provided on a given work shift. Annapolis has 6 clinical nurse supervisors. The most authoritative nursing official at each of the hospitals is the nursing site leader (sometimes also called director of patient care services). Annapolis's nursing site leader is Kathleen Cronin. Each nursing site leader reports dually to her hospital's site administrator -- at Annapolis, Chief Administrative Officer Tom Kochis -- and to the corporate chief nursing officer, currently Interim Chief Maria Strom.[4] Strom superintends nursing practice across the entire OHI system, including the acute-care hospitals, the ambulatory and long-term care facilities, and the home care network. The parties stipulated, and I concur, that the individuals occupying positions at the level of assistant clinical manager and higher are statutory supervisors with authority to exercise indicia of authority as set forth in Section 2(11) of the Act. Accordingly, the 232 nurses at Annapolis are supervised by a supervisory/management staff of 34.

All registered nurses at the hospitals report directly to on-site nursing supervisors. With the recent advent of "service line" reporting configurations, however, the upper reach of supervisory hierarchy for nurses in certain specialties includes individuals who oversee that nursing specialty at more than one site. Nonetheless, the development of "service lines" has not erased the primacy of first-line supervision nor diminished the authority of the nursing site leader. A

[4] The Employer asserts, without record citation, that the nursing site leader reports only to the corporate chief nursing officer and not her site administrator. (Br. 30-31) That the nursing site leader reports to both is reflected in at least two exhibits regarding organizational structure.

communication chain of command is contained in several written directives issued by the corporate Human Resources Department and approved by the Acute Care Nursing Operations Council. These policies specify that a nurse or charge nurse encountering any sort of patient, operational, or ethical problem is expected to notify a clinical manager or clinical nurse supervisor. The latter contacts the nursing site leader, who consults with the site administrator, service line leader, or risk manager as deemed necessary.[5]

Staffing and scheduling guidelines emanate from the corporate Human Resources Department. These precepts are further refined by the Acute Care Nursing Operations Council. The work schedule for nurses on each nursing unit must be posted for four weeks. The corporation has adopted what is considered a standard work day, and also offers nurses the option of working alternative schedules. Within these parameters, specific choices of unit shifts (days, evenings, midnights, or rotation) and hour patterns (4-hour, 8-hour, 10-hour, or 12-hour) are established by the unit's clinical manager. Requests for shift changes must be made in writing and submitted to the clinical manager. Employees may adjust their schedules by trading with colleagues, but all trades must be requested of and approved in advance by the clinical manager. The amounts of allotted vacation time, sick leave, and personal time are centrally prescribed, but specific requests for vacation time and other leave are submitted to and acted upon by the nurse's immediate site supervisor. In particular, the clinical manager sets the limit on the number of simultaneous vacations that she will allow.

OHS enforces an across-the-board policy forbidding mandatory overtime, but overtime will be scheduled and offered in emergencies. The clinical manager or clinical nurse supervisor determines whether an emergency exists, and all overtime must be approved in advance by those individuals. The corporation has a uniform attendance program that correlates discipline with the number of unexcused absences. The clinical manager has discretion to characterize an "emergency" absence as excused and an undocumented absence as unexcused.

Staffing guidelines are centrally determined, and are based on prescribed criteria such as patient census and acuity. The clinical nurse supervisor is responsible for assuring that adequate staff is available and for initiating the use of overtime, system or in-house flex pool nurses, or outside agency nurses to cover staffing shortages. Each hospital's nursing site leader maintains 24-hour accountability and availability to assure that appropriate staffing levels are continuous.

[5] Because there is some conflict among witnesses, and between testimony and exhibits, the record is less than crystalline regarding which specialties are "service lines." It is clear that out of a nursing staff at Annapolis of 232, 65 to 70 nurses are in "service lines."

An inter-site nursing leadership council has devised detailed job descriptions for each nursing position. As noted above, each job has a set wage range from which site managers may not vary. A newly hired or transferred nurse is assigned a wage rate within the range based upon her level of experience, in accordance with a centrally determined grid. How years of experience for this purpose are counted or weighted is not disclosed in the record. The wage ranges for each job classification are uniform across the four acute-care hospitals.

All employees subject to the handbook receive periodic performance appraisals, prepared by immediate site supervisors on centrally prescribed forms. The supervisor assigns a numerical rating in specific areas, and the individual ratings are converted, in accordance with a predetermined formula, into an overall score. As stated in the handbook, all employees with a final score of 100 or more are entitled to whatever across-the-board pay increase that the Employer chooses to implement. Any applicable pay increase will be the same for all eligible employees, regardless of the exact appraisal score.

The handbook states that OHS encourages inter-corporate voluntary job transfers as a way for employees to seek personal advancement. All employees with six months' seniority in their present position, who have been free of disciplinary suspensions within the last two years, are eligible for a voluntary transfer. A nursing site leader may grant an exception to the six-month requirement. A nurse initiates a voluntary transfer by completing a transfer request form and submitting it to the Human Resources Department. The clinical manager of the unit being requested receives a copy of such request. As a position becomes available, the clinical manager interviews all applicants who meet the foregoing minimal requirements. Prior to making her decision, the clinical manager of the receiving unit will request background information from the transferring clinical manager. The receiving clinical manager makes the final selection, utilizing defined clinical criteria. A nurse who transfers to a new site may carry her accumulated sick and vacation time, but not unused holidays or personal days. Her length of service will follow her to the new site for the purpose of determining eligibility for service awards, vacation, sick time, and health benefits.

Nurses normally may not use their corporate seniority to "bump" into the position of a less senior nurse at a different site. Such bumping is theoretically permitted only in the case of a reduction of force *and* if the two nurses are in the same service line. Whether these twin conditions have ever been met so as to trigger an occasion of bumping was not disclosed in the record.[6]

[6] The Employer's closure of the Annapolis-Westland behavioral health facility in 1997 affected 20 nurses. According to Verna Bastedo, their unionized status meant that OHS' bumping procedures did not apply. Nonetheless, 13 of the 20 nurses were offered jobs in OHS' acute-care hospitals. Obstetric units in Seaway

During the 14.5 month period preceding the hearing in this case, 9 nurses permanently transferred from Annapolis to another OHS acute-care hospital, and 24 nurses permanently transferred to Annapolis. In relation to the 232-nurse complement at Annapolis, this is a transfer rate of 14%. Of the 24 in-coming transfers, 14 were occasioned by the closing of Beyer Hospital, an acute-care facility formerly part of Oakwood United Hospital, Inc. The record does not reveal the reason for the other Annapolis transfers, or whether they were voluntary or involuntary. If the Beyer closing did not occur during the selected time span, Annapolis's transfer rate would be 8%.

During the same period, 24 nurses made permanent transfers among OHMC, Seaway, and Heritage. In addition, OHMC, Seaway, and Heritage also absorbed 23 nurses due to OHI's closing of Beyer Hospital. Excluding the Beyer transfers as non-recurring events yields a transfer rate among OHMC, Seaway, and Heritage of less than 1.5%.

During the 5-month period ending shortly before the hearing, there were 7 temporary transfers of nurses from other OHS hospitals into Annapolis, and 63 temporary transfers of Annapolis nurses to other hospitals. The intervals of time spent working at the outside site varied; most exceeded eight hours. The preponderance of such temporary transfers was due to the assignment of flex pool staff, nurses who receive premium pay in exchange for working flexible schedules. The reasons for these temporary transfers were not explored at the hearing.

Other than the contact occasioned by the transfers described above, nurses from one site may encounter nurses from another during the corporate stage of new employee orientation. This program, which follows a uniform syllabus, takes place at a central corporate office and is attended by all newly hired nurses. Nurses also receive site-specific orientation upon being hired or transferred.

Congress instructed the Board to make unit findings so as "to assure to employees the fullest freedom in exercising the rights guaranteed by this Act." 29 U.S.C. §159(b). It is axiomatic that nothing in the Act requires a bargaining unit to be the *only*, or the *ultimate*, or the *most appropriate* grouping. ***Overnite Transportation Co.***, 322 NLRB 723 (1996); ***Capital Bakers***, 168 NLRB 904, 905 (1967); ***Morand Bros. Beverage Co.***, 91 NLRB 409 (1950), enfd. 190 F.2d 576 (7th Cir. 1951). A union need not seek representation in the most comprehensive grouping of employees unless an appropriate unit compatible with the union's

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and Beyer, a now defunct facility, also closed in recent years. There is testimony that affected nurses were absorbed into the corporate system and retained their seniority, but no indication that they displaced other nurses via bumping.

request does not exist. ***Purity Food Stores***, 160 NLRB 651 (1966); ***P. Ballantine & Sons***, 141 NLRB 1103 (1963). A union's desire is always a relevant, although not a dispositive, consideration. ***E. H. Koester Bakery & Co.***, 136 NLRB 1006 (1962).

A single facility of a multi-location employer is a presumptively appropriate unit. ***Hegins Corp.***, 255 NLRB 160 (1981). The Board, with court approval, uses the same single-facility presumption in fashioning health care units. ***Manor Healthcare Corp.***, 285 NLRB 224 (1987); ***Presbyterian University Hospital v. NLRB***, 88 F.3d 1300, 1309 (3rd Cir. 1996); ***Staten Island University Hospital v. NLRB***, 24 F.3d 450, 456-467 (2nd Cir. 1994).

Manor Healthcare mandates consideration of traditional factors in deciding whether the presumption has been overcome. Such factors are geographic proximity, bargaining history, employee interchange and transfer, functional integration, administrative centralization, and common supervision. Thus, the presumption is normally overcome only if employees from the single location have been blended into a wider unit by bargaining history, or if the single location has been so integrated with a wider group as to cause it to lose its separate identity. ***Heritage Park Health Care Center***, 324 NLRB 447, 451 (1997), enfd. 159 F.3d. 1346 (2nd Cir. 1998); ***Passavant Retirement & Health Center***, 313 NLRB 1216 (1994); see also ***Centurion Auto Transport***, 329 NLRB No. 42 (1999). The presumption may also be rebutted in the health care setting by a showing that approval of a single-facility unit will increase the kinds of disruptions to continuity of patient care that Congress sought to prevent in cautioning against proliferation of units in the health care industry. ***Mercywood Health Building***, 287 NLRB 1114, 1116 (1988), enf. denied on other grounds sub. nom. ***NLRB v. Catherine McAuley Health Center***, 885 F.2d 341 (6th Cir. 1989).

OHI has undertaken a number of measures to streamline its enterprises. This has resulted in centralization of many administrative functions, including marketing, purchasing, recruitment, payroll, and human resources. Wages, benefits, and disciplinary procedures exhibit a high degree of uniformity. The advent of service lines affects the reporting structure by making certain mid- and high- level nursing supervisors responsible for coordinating nursing services at more than one facility.

Nonetheless, each nurse at Annapolis reports to a supervisor on site, and on-site management still exercises significant autonomy over the Annapolis nurses' quotidian work lives. Clinical managers (or their on-site service line equivalent) control work schedules, choice of shifts, and hours. They grant or deny leave requests, determine how many vacations will be permitted at a time, and decide whether overtime will be worked. Site supervisors interview and select

new hires and transferees from pools of eligible nurses. A clinical manager has some discretion in the classifying of an absence as excused or unexcused.

Site supervisors initiate all disciplinary actions, and, as far as the record reveals, take conclusive unilateral action with respect to counseling and written warnings. Similarly, site supervisors have the authority to resolve grievances at the first two steps of the dispute resolution procedure. A nurse's job performance appraisal by her site supervisor determines her eligibility for any across-the-board wage increase. When professional, operational, and ethical problems arise, nurses are specifically instructed to adhere to a chain of command that originates at the first level of nursing management at the site, the clinical manager, and travels through the site's hierarchy to the nursing site leader.

The foregoing recital demonstrates that within OHI's framework, Annapolis nurse management retains significant authority. The presence of local control is a decisive factor and overcomes even strong evidence of centralization. ***NLRB v. HeartShare Human Services of New York, Inc.***, 108 F.3d 467 (2nd Cir. 1997), enforcing 317 NLRB 611 (1995) (finding single facility appropriate). In ***RB Associates***, 324 NLRB 874 (1997), the Board, relying in part on the existence of local supervision, found a single hotel unit to be appropriate, despite the close proximity of other hotels; common personnel policies, handbook, benefits, rules, and regulations; central hiring; commonly conducted orientation; intercession of a corporate human resource director in hiring, discipline, and performance evaluations; identical employee skills and functions; and open transfers without loss of benefits or seniority. See also ***Children's Hospital of San Francisco***, 312 NLRB 920 (1993), enfd. sub. nom. ***California Pacific Medical Center v. NLRB***, 87 F.3d 304 (9th Cir. 1996).

Annapolis is a discrete facility, geographically separated from the other acute-care hospitals. It is 8 miles away from Heritage, 10 from OHMC, and 22 miles distant from Seaway. Compare ***NLRB v. Catherine McAuley Health Center***, supra at 347-348 (single-facility presumption inapplicable because sought unit, formerly geographically distant, has been physically relocated to central campus); ***Lutheran Welfare Services of Northern Pennsylvania***, 319 NLRB 886 (1995) (facilities only 100-200 feet apart separated by parking lot). There is no relevant bargaining history in this case militating against the appropriateness of a single-facility finding.

The evidence does not show, nor does OHI contend, that a single-facility unit finding will threaten the continuity of patient care. ***Hartford Hospital***, 318 NLRB 183, 193 (1995), enfd. 101 F.3d 108 (2nd Cir. 1996).

The evidence of interchange in the instant case is limited. The majority of permanent transfers in the period under examination was caused by the closure of an acute-care hospital, a relatively rare event. The remaining permanent transfers were statistically negligible in the overall unit sought by OHI, and hardly decisive at Annapolis. Many more temporary transfers were attributable to the use of flex pool nurses than to migration of the stationary nursing corps.

I find the cases relied upon by the Employer to be distinguishable. In ***West Jersey Health System***, 292 NLRB 749 (1989), the Board had a concern, absent here, that unit fragmentation would adversely affect patient care services. The record in ***West Jersey*** also demonstrated considerably more employee interchange, with 147 permanent transfers in a 14-month period, regular temporary rotation of unit employees to other facilities, and the availability of seniority bumping rights.[7] In ***Presbyterian/St. Luke's Medical Center***, 289 NLRB 249 (1988), the Board found that a "significant number" of transfers had occurred and that physicians need not make separate applications, as they do here, to be admitted to practice. In ***Montefiore Hospital***, 261 NLRB 569 (1982), neither party sought a single-facility unit, and the Board's task was to delineate an appropriate unit among competing multi-location groupings.

OHI has adduced evidence tending to show that a unit comprised of its four acute-care hospitals may be appropriate. However, that a wider unit may be appropriate does not imply that a narrower one is inappropriate. ***Children's Hospital of San Francisco***, supra at 928. OHI bears the burden of establishing that consolidation and centralization have destroyed Annapolis's identity. For the reasons discussed above and based upon the entire record, I find that OHI has not met that burden.

Accordingly, I find that the following employees of the Employer constitute a unit appropriate for purposes of collective bargaining within the meaning of Section 9(b) of the Act, and I hereby direct an election therein:

> All full-time and regular part-time registered nurses employed by the Employer at its Oakwood Annapolis Hospital facility in Wayne, Michigan, including in-house flex pool and contingent nurses,[8] staff nurses, RN first assistants, staff nurse anesthetists, cardiac cath lab

[7] In ***West Jersey***, employees could transfer by exercising bumping rights. At OHI, no voluntary transfers may be accomplished by bumping. Rather, seniority may be exercised on an inter-site basis only within the same service line during a reduction in force.

[8] The parties stipulated to the eligibility of in-house flex pool and contingent nurses who have worked at least 72 hours in the quarter immediately preceding the election eligibility date. Based on the record, and in conformity with a similar stipulation and finding in the 1994 Heritage decision, I adopt this stipulation. The parties stipulated to the ineligibility of system flex pool nurses. Based on the record and community of interest factors, I concur in this stipulation.

nurses, clinical educators, and case managers; but excluding nursing site leaders, clinical managers, assistant clinical managers, clinical nurse supervisors, OR service managers, pre-admission testing coordinators, system flex nurses, home care nurses, all other employees, and guards and supervisors as defined in the Act.

Those eligible shall vote as set forth in the attached Direction of Election.

Dated at Detroit, Michigan, this 9th day of May, 2001.

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440-1720-0133